Commentary

Commentary From Coeur d'Alene: 1984—A Year of Prophecy?

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We are now in the year 1984, the fateful year of Orwellian prophecy. We could wish that somehow each of us might be granted the ability to prepare for the future by looking into the past, like the mythical god Janus, who with his two faces could look both backward and forward.

Were we to attempt forecasting the future of medicine, let us hope that we would do it with optimism, and less of the pessimism of a George Orwell.

Every student of the history of medicine must come to this realization: The practice of medicine is dynamic, ever changing with the swings of the pendulum of public opinion, just as the physician's image undergoes wide swings in popularity.

Only 150 years ago, during the Jacksonian era, the medical profession was held in low esteem, and medical licensure carried with it little honor. Indeed, the image of physicians had sunk so low that several state legislatures wanted to do away with medical licensure altogether.

Medicaments, as such, were to be avoided; home remedies abounded. Natural forces were relied upon to bring about healing. Illness was considered punishment for sin, and health came from God, not from doctors.

There was no pride attached to the name "doctor of medicine," and even then the authority of physicians was being questioned by an increasingly aggressive nursing profession.

With the passing years a gradual change took place. During the first five or six decades of this 20th century the status of the medical profession rose to new heights. The "good doctor" who sat by the bedside, who brought health and babies in his black bag, was again deified by his loyal patients. Once more the popularity polls placed physicians at the top, right along with members of the clergy.

Today there are indications that medical history is repeating itself, that the pendulum is again on the downswing.

The legislature of a large, progressive bellwether state we often look to for leadership has questioned the need for medical licensure. "Natural" foods, medicines and herbs are extolled. Faddists and quacks have subverted the fine qualities of holistic medicine. *PDRs* are sold in book stores, ostensibly to enable patients to question prescriptions physicians have given them. Advice from talk show hosts and lay magazines often outweighs the doctors' opinions.

Paraprofessionals or, as they prefer to be called, allied health care professionals are bringing pressure to be given medical staff privileges, with the right to admit and treat patients in hospital. The Joint Commission on the Accreditation of Hospitals and the American Medical Association are on the horns of a dilemma, squeezed between the urgings of medical staffs and the fears of restraint of trade legislation.

An intensive care unit nurse in Harbor City, California, refuted the order of two respected physicians, and she subsequently brought a lawsuit against them. And in a recent popularity poll, physicians dropped to a lowly third place, well behind the clergy and pharmacists.

All this comes as a blow to the pride of this physician who has worn out three "black bags." Where have we gone wrong? What can we do about it?

Troubled by these same problems, the Ohio State Medical Association (OSMA) wisely went to its member physicians, setting up discussion panels throughout the state.[1] There was considerable heat and a modicum of light developed by these panel discussions.

Third-party payors, government intrusion, prepayment medicine—these were blamed for putting the fee-for-service type of practice into jeopardy. In general, their discussions reflected a sense of despair.

Patient "education" was deplored as inadequate and superficial. They called for the medical profession to "get into the act," and at the same time begin to "blow your own horn." After all, they said the Latin word for "doctor" translates "teacher."

The increase in liability suits was viewed as a result of, rather than a cause of, the diminished physician

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image. In yesteryear no one would ever think of suing the "good doctor."

The institutionalization of medicine, snug in the womb of the hospital, together with the snaring by emergency rooms of the patients who previously would have gone to a doctor's office, have served to detract from the image of private physicians, especially that of family physicians.

Further, the OSMA panel members concluded that advanced technology must also share some of the blame for the lessened physician stature. Our new sophisticated gadgetry has brought with it the battalions of allied health care professionals needed to keep the machines running. The young respiratory technician with a stethoscope draped around his neck gets a glow out of being addressed as "Doctor" by a patient on the ward. How are these patients to know who is a "real" doctor?

In health care, as in home repairs, everyone is now being urged to "do it yourself." Technology has given our patients the ability to check their own blood pressure and blood glucose values, and there now are pregnancy testing kits for home use. Why then consult a doctor or pay for an office call?

The OSMA panelists did arrive at a consensus: Individual physicians' organizations must try harder to influence legislators and the public. The value of political action committee activities was recognized, but there was a fear that too often we contributed our dollars and let it go at that.

In that same context, James L. Breen, in delivering his presidential address to the American College of Obstetricians and Gynecologists,[2] reminded us that 31 physicians took part in the First Continental Congress and 6 physicians were signers of the Declaration of Independence.

One additional and terribly important factor in this downgrading of the physician's image must be mentioned: That is the trend toward specialization and subspecialization, to the detriment of the generalist. An editorial in *JAMA*[3] deplores the increasing influences of specialists and subspecialists, particularly in hospital practice. This is by no means a baseless fear. The executive committee of our community hospital staff, under a plan of "departmentalization," will be made up of nine specialists and subspecialists, and *one* generalist.

The administrator of our hospital proudly announced to the local press (*The Spokesman-Review,* Spokane, Wash, Jan 8, 1984) that

> The hospital opened in 1966 with a staff consisting almost entirely of general practitioners, with one or two surgeons. Half of the present staff has arrived since 1977, and the list now includes specialists and subspecialists in neurology, rheumatology, gastroenterology, among others.

Robert G. Petersdorf, dean of the University of California, San Diego, School of Medicine, speaking at the Washington State Medical Association's annual meeting,[4] contended that we are entering a period of "future shock" as students are lured away from general practice by the glamour of the subspecialties.

In an article, "American Doctors—A Profession in Trouble," *US News and World Report* editor Britt looked at the many forces that threaten "medicine's rugged individualism of the past" (*US News and World Report,* October 17, 1977). She bemoaned the fact that "Today only one-seventh of this country's physicians are in primary care—although 90% of the problems that send patients to the doctor do not require specialty training."

All will agree that the downswing in the image of primary physicians has resulted in a great part from the upswing in medical technology. The specialists control the diagnostic and therapeutic machinery, and therein lies the glamour.

However, this addiction to technology has produced what Dr Ralph Cramshaw[5] calls "a new, dangerous iatrogenic disease, the syndrome of the technical fix." Cramshaw protests, "Physicians appear blind to how the machine intervenes between the patient and the doctor." He calls for a rethinking of the physician-machine relationship.

There may already be forces at work in this year of prophecy, forces that will temper the winds of technology, saving us from being captives of our own sophisticated machinery.

One force, and a potent one, is the economy. For more than a decade we, the physicians, the hospitals and our patients, have been living high at the medical care banquet table. First class care was promised to one and all. This included unlimited CT scans, sonograms, arterial gas determinations, fetal monitoring and laboratory tests ad infinitum. Not to worry about costs —our patients are "covered" by third-party payors, Medicare and a benevolent Big Brother in Washington.

Yet Big Brother has now, belatedly, awakened to the fact that the banquet must come to an end. The first class medical meals must be pared down to tourist class. And this is to be accomplished through the use of Diagnosis Related Groups (DRGs).

DRGs are hailed by some and damned by others. Hospital administrators are suddenly confronted with a prospect of red ink on the balance sheet after a long and euphoric period of black-ink prosperity. Nursing staffs are being cut, formularies are being narrowed (first-generation cephalosporins will do), and we staff members are being urged, even pressured, to limit our ordering of the batteries of exotic tests that only yesterday seemed so necessary. We are learning, also, that we had best discharge our patients promptly, within the DRG time limitation.

Now then who among us, the primary physician or the superspecialist, has most often been guilty of ordering the batteries of "unnecessary" tests, or of prolonging the hospital stay for just one more diagnostic dessert?

Although the DRG system of payment so far applies only to Medicare patients, it is conceded that if the plan proves cost-effective it will be extended to a full

range of patient care reimbursement. This may be considered by some as another third-party intrusion, and yet it could bring with it some benefits not originally perceived by the designers of the plan.

As Dr Malcolm Watts has pointed out in an editorial in this journal,[6] "In recent years a strong focus on medical science has somewhat overshadowed the art . . . it would seem that DRGs will add yet another dimension to this art of a practicing physician . . . in both the patient and the public interest."

There are still other potent facts pointing us away from the impersonal, mechanized, specialized medical care. In several subtle ways our patients are pleading for a return to the "rugged individualism" of medical practice. Home health care, hospice, birthing rooms, free-standing surgicenters, drop-in "urgency centers," all tell us that the public yearns for a return to the "good doctor" who is both friend and physician.

One present-day oracle, John Naisbitt, the author of *Megatrends*,[7] writes with optimism that George Orwell did not possess. Naisbitt believes that we have been living in "a time of parenthesis, a time between eras." He believes that in the era ahead of us, whether in business, industry or medicine, "if you specialize too much, you may become obsolete. Now we need more generalists who are constantly remodeling their skills." He, too, is calling for a return to the art of medicine.

Private practice is not dead, but alive and well. The primary physician, even the much maligned solo practitioner, would seem to be standing on the threshold of a new era, looking forward to a brightened physician image, as once again the pendulum swings.

REFERENCES

1. Mullinax CW: Ohio MDs probe the future of medicine. AM News 1982 Dec 10; 25:33

2. Breen JL: What was, what is, and what may be. Obstet Gynecol 1983 Oct; 26:401-407

3. Davidson RA: Birds, fish and subspecialists—A common pathway to extinction. JAMA 1983 Sep 16; 250:1386

4. Seil W: 'Future shock' hits internists, subspecialties lure students. West J Med/WSMA Reports, October 1983, p 8

5. Cramshaw R: Technical zeal or therapeutic purpose—How to decide? JAMA 1983 Oct 14; 250:1857-1859

6. Watts MSW: DRGs and the art of medicine (Editorial). West J Med 1984 Jan; 140:92-93

7. Naisbitt J: Megatrends—Ten New Directions Transforming Our Lives. New York, Warner Books, 1983